

MISSOURI STATE BOARD OF HEALTH

BUREAU OF VITAL STATISTICS

CERTIFICATE OF DEATH

43528

Do not use this space.

1. PLACE OF DEATH

(a) County Howell - City Registration District No. 2 384
 (b) Township West Plains Mo Primary Registration District No. 4227
 (c) City West Plains Mo (d) Street No. _____
 (If death occurred in Hospital or Institution, write its name instead of street and number)
 (e) Length of residence in city or town where death occurred yrs. mos. ds. (f) How long in U. S., if of foreign birth? yrs. mos. ds.

Registered No. _____

2. PRINT FULL NAME

(a) Residence, No. _____ St. (If nonresident, give city or town and State)
 (Usual place of abode, if no street address, write county or city)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED, OR DIVORCED Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Flora Stephens

6. DATE OF BIRTH (MONTH, DAY, AND YEAR) 10-17-83

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
56 1 25

8. Trade, profession, or particular kind of work done, as sawyer, bookkeeper, etc. Nurseryman

9. Industry or business in which work was done, as saw mill, bank, etc. _____

10. Date deceased last worked at this occupation (month and year) _____ 11. Total time (years) spent in this occupation _____

12. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Shannon Co Mo

13. NAME Joseph Stephens

14. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill 1

15. MAIDEN NAME Emma

16. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY) Ill

17. INFORMANT (ADDRESS) Prover Gray

18. BURIAL, CREMATION, OR REMOVAL PLACE Langston Cemetery DATE 12/13-39

19. FUNERAL DIRECTOR (NAME) (ADDRESS) Robertson's Mortuary
West Plains Mo

20. FILED 12-13, 1939 Vida W. SIMONS
Local Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH (MONTH, DAY, AND YEAR) 12-12-39

22. I HEREBY CERTIFY, That I attended deceased from Sept, 1939 to 12-11-, 1939

I last saw him alive on 12-11-, 1939. Death is said to have occurred on the date stated above, at 4 p. m.

The principal cause of death and related causes of importance were as follows:

Chronic Myocarditis
Hypertension
General Atherosclerosis

Date of onset

Other contributory causes of importance: 930

Name of operation _____ Date of _____

What test confirmed diagnosis? exam Was there an autopsy? no

23. If death was due to external causes (violence), fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19 _____

Where did injury occur? _____ (Specify city or town, county, and State)

Specify whether injury occurred in industry, in home, or in public place.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? no

If so, specify _____

(Signed) E. C. Johner, M. D.

(Address) West Plains Mo

(Licensed Embalmer's Statement on Reverse Side)

Blonde Baker

WRITE PLAINLY, WITH UNFADING INK---THIS IS A PERMANENT RECORD

5010-3-19-35 I X16605

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

RECEIVED

District Health Officer No. 5,

Signed.....

District File Number 14037

Licensed Embalmer No.....

Date Filed 11040

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.